		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044263

Facility Name: GILMAN NURSING PAVILION

Address: ROUTE 45 SOUTH (Number) GILMAN (City) 60938 (Zip Code)

County: IROQUOIS

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-4264598

Date of Initial License for Current Owners: 01/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,643	2,643	8
9	SNF/PED					9
10	ICF	18,158	7,735		25,893	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,158	7,735	2,643	28,536	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.97%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided 2,482

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,706	10,912	5,705	189,323		189,323		189,323			1
2	Food Purchase		135,256		135,256	(19,564)	115,692	(1,371)	114,321			2
3	Housekeeping	95,605	17,282		112,887		112,887		112,887			3
4	Laundry	35,148	11,100	3,370	49,618		49,618		49,618			4
5	Heat and Other Utilities			86,331	86,331		86,331	715	87,046			5
6	Maintenance	28,904	18,706	7,413	55,023		55,023	5,152	60,175			6
7	Other (specify):*			5,221	5,221		5,221	391	5,612			7
8	**TOTAL General Services**	332,363	193,256	108,040	633,659	(19,564)	614,095	4,887	618,982			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,082,604	41,779	4,260	1,128,643		1,128,643	(118)	1,128,525			10
10a	Therapy		1,061	3,636	4,697		4,697		4,697			10a
11	Activities	89,580	5,014		94,594		94,594		94,594			11
12	Social Services	36,906		1,924	38,830		38,830		38,830			12
13	Nurse Aide Training											13
14	Program Transportation			96	96		96		96			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,209,090	47,854	11,116	1,268,060		1,268,060	(118)	1,267,942			16
	C. General Administration											
17	Administrative	68,766			68,766		68,766	129,461	198,227			17
18	Directors Fees											18
19	Professional Services			30,060	30,060		30,060	1,708	31,768			19
20	Dues, Fees, Subscriptions & Promotions			36,854	36,854		36,854	(29,004)	7,850			20
21	Clerical & General Office Expenses	37,101	16,949	265,841	319,891		319,891	(206,290)	113,601			21
22	Employee Benefits & Payroll Taxes			245,506	245,506	19,564	265,070		265,070			22
23	Inservice Training & Education			1,831	1,831		1,831		1,831			23
24	Travel and Seminar							393	393			24
25	Other Admin. Staff Transportation			10,442	10,442		10,442		10,442			25
26	Insurance-Prop.Liab.Malpractice			59,485	59,485		59,485	2,145	61,630			26
27	Other (specify):*							19,049	19,049			27
28	**TOTAL General Administration**	105,867	16,949	650,019	772,835	19,564	792,399	(82,538)	709,861			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,647,320	258,059	769,175	2,674,554		2,674,554	(77,769)	2,596,785			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,280	
	REPAIRS & MAINTENANCE		425	
			0	5,705
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,370	
			0	3,370
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		3,405	
	ELECTRICITY		61,105	
	WATER		21,821	
	CABLE TV - LOBBY		0	
			0	86,331
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,311	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		3,178	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		924	
	FIRE SERVICE		0	
			0	
			0	
			0	7,413
7	**OTHER**			
	SCAVENGER		5,221	
	SECURITY SERVICE		0	5,221
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,260	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,260
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,774	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,836	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	26	3,636
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,924	
			0	1,924
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		96	96
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,956	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,104	
			0	30,060
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	27,308	
	EMPLOYEE WANT ADS	XIX F	25	
	CONTRIBUTIONS	VI 20 XIX F	670	
	DUES & SUBSCRIPTIONS	XIX F	5,089	
	LICENSES & PERMITS	XIX F	1,158	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,674	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	930	36,854
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		19,026	
	OUTSIDE CLERICAL SERVICES		226,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,704	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,111	
	MESSENGER SERVICE		0	
			0	265,841

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	122,760	
	UNEMPLOYMENT COMPENSATION	XIX D	9,449	
	WORKERS COMPENSATION INSURANCI	XIX D	51,227	
	HOSPITALIZATION INSURANCE	XIX D	53,552	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,518	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	245,506
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,831	1,831
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,442	10,442
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		59,485	59,485
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 769,175

Facility Name & ID Number GILMAN NURSING PAVILION #0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,610	41,610		41,610	(5,385)	36,225			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,475	45,475		45,475	2,081	47,556			32
33	Real Estate Taxes			44,730	44,730		44,730	1,735	46,465			33
34	Rent-Facility & Grounds			462,000	462,000		462,000		462,000			34
35	Rent-Equipment & Vehicles			4,339	4,339		4,339	4,776	9,115			35
36	Other (specify):*											36
37	TOTAL Ownership			598,154	598,154		598,154	3,207	601,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,366	129,166	194,532		194,532	(67)	194,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		65,366	183,369	248,735		248,735	(67)	248,668			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,647,320	323,425	1,550,698	3,521,443		3,521,443	(74,629)	3,446,814			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,802)	30		9
10	Interest and Other Investment Income	(207)	32		10
11	Discounts, Allowances, Rebates & Refunds	(537)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(834)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,704)	21		18
19	Entertainment		20		19
20	Contributions	(2,344)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(237)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(27,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,973)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,656)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,656)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,629)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GILMAN NURSING PAVILION

ID# 0044263

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,371)	0	0	0	0	0	0	0	0	0	0	(1,371)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	715	0	0	0	0	0	0	0	0	715	5
6	Maintenance	0	0	570	4,582	0	0	0	0	0	0	0	5,152	6
7	Other (specify):*	0	0	0	0	391	0	0	0	0	0	0	391	7
8	**TOTAL General Services**	(1,371)	0	1,285	4,582	391	0	0	0	0	0	0	4,887	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(118)	0	0	0	0	0	(118)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(118)	0	0	0	0	0	(118)	16
	C. General Administration													
17	Administrative	0	0	0	129,461	0	0	0	0	0	0	0	129,461	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(237)	0	1,945	0	0	0	0	0	0	0	0	1,708	19
20	Fees, Subscriptions & Promotions	(29,652)	0	648	0	0	0	0	0	0	0	0	(29,004)	20
21	Clerical & General Office Expenses	(10,704)	(226,000)	26,137	4,277	0	0	0	0	0	0	0	(206,290)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	393	0	0	0	0	0	0	0	0	393	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,145	0	0	0	0	0	0	0	0	2,145	26
27	Other (specify):*	0	0	4,468	0	14,581	0	0	0	0	0	0	19,049	27
28	**TOTAL General Administration**	(40,593)	(226,000)	35,736	133,738	14,581	0	0	0	0	0	0	(82,538)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,964)	(226,000)	37,021	138,320	14,972	(118)	0	0	0	0	0	(77,769)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(7,802)	0	2,417	0	0	0	0	0	0	0	0	(5,385)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(207)	0	2,288	0	0	0	0	0	0	0	0	2,081	32
33	Real Estate Taxes	0	0	1,735	0	0	0	0	0	0	0	0	1,735	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	4,776	0	0	0	0	0	0	0	0	4,776	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,009)	0	11,216	0	0	0	0	0	0	0	0	3,207	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(67)	0	0	0	0	0	(67)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(67)	0	0	0	0	0	(67)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,973)	(226,000)	48,237	138,320	14,972	(185)	0	0	0	0	0	(74,629)	45

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING SERVICES	$ 226,000	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (226,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 226,000			$	$ * (226,000)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 715	$ 715	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	570	570	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "	100.00%			17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	1,945	1,945	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	648	648	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	26,137	26,137	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	393	393	21
22	V	26	INSURANCE		" " "	100.00%	2,145	2,145	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	4,468	4,468	23
24	V	30	DEPRECIATION		" " "	100.00%	2,417	2,417	24
25	V	32	INTEREST		" " "	100.00%	2,288	2,288	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	1,735	1,735	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	4,776	4,776	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 48,237	$ * 48,237	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 4,582	$ 4,582	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	25,500	25,500	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	37,496	37,496	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	31,853	31,853	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	7,039	7,039	21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	7,035	7,035	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	8,786	8,786	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	11,752	11,752	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	4,277	4,277	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 138,320	$ * 138,320	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 391	$ 391	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	809	809	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	1,248	1,248	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	5,345	5,345	19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%	2,663	2,663	21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	618	618	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,271	1,271	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,785	1,785	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	842	842	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 14,972	$ * 14,972	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	470	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	352	(118)	21
22	V	39	ANCILLARY EXPENSE	266	" " "	100.00%	199	(67)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 736			$ 551	$ * (185)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 25,500	17-7	1
2	MAURY AARON		ADMINISTRATIVE					SALARY	37,496	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	31,853	17-7	3
4	STEVE LEVY		ADMINISTRATIVE					SALARY	8,786	17-7	4
5	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	7,039	17-7	5
6	SHARON AARON		CLERICAL					SALARY	4,277	21-7	6
7	DIANIA MAGAFAS		ADMINISTRATIVE					SALARY	7,035	17-7	7
8	DENNIS NEHMER		MAINTENANCE					SALARY	4,582	6-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 126,568		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	423,801	12	$ 10,611	$	28,536	$ 715	1
2	6	REPAIR & MAINT.	" "	423,801	12	8,462		28,536	570	2
3	7	EMP. BEN. - GEN, SERVICES	" "	423,801	12			28,536	0	3
4	19	PROFESSIONAL FEES	" "	423,801	12	28,879		28,536	1,945	4
5	20	DUES AND SUBSCRIPTION	" "	423,801	12	9,628		28,536	648	5
6	21	CLERICAL & GENERAL	" "	423,801	12	388,179	279,093	28,536	26,137	6
7	24	SEMINARS AND TRAVEL	" "	423,801	12	5,844		28,536	393	7
8	26	INSURANCE	" "	423,801	12	31,856		28,536	2,145	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	423,801	12	66,362		28,536	4,468	9
10	30	DEPRECIATION	" "	423,801	12	35,898		28,536	2,417	10
11	32	INTEREST	" "	423,801	12	33,975		28,536	2,288	11
12	33	REAL ESTATE TAXES	" "	423,801	12	25,761		28,536	1,735	12
13	35	EQUIPMENT RENTAL	" "	423,801	12	70,935		28,536	4,776	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 48,237	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 59,901	$ 59,901	3	$ 4,582	1
2	10	NURSING CMP. - SUE G.	" "							2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	373,726	373,726	3	25,500	3
4	17	ADMIN. CMP. - M. AARON	" "	40	9	490,141	490,141	3	37,496	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,118	191,118	8	31,853	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	40	3	49,500	49,500			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	69,097	69,097	4	7,039	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	77,417	77,417	4	7,035	8
9	17	ADMIN. CMP. - E. CASSON	" "							9
10	17	ADMIN. CMP. - S. BOGEN	" "	11	2	40,545	40,545			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	11	128,818	128,818	3	8,786	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	9	153,735	153,735	3	11,752	13
14	21	ADMIN. CMP. - S. AARON	" "	40	11	62,676	62,676	3	4,277	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,674	$ 1,708,674		$ 138,320	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,106	$	3	$ 391	1
2	15	EMP. BEN. - SUE G.	" "							2
3	27	EMP.BEN. - M. MAUER	" "	40	11	11,858		3	809	3
4	27	EMP. BEN. - M. AARON	" "	40	9	16,312		3	1,248	4
5	27	EMP. BEN. - F. AARON	" "	45	6	32,071		8	5,345	5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	40	3	26,160				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	7	26,142		4	2,663	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	6,801		4	618	8
9	27	EMP. BEN. - E. CASSON	" "					3		9
10	27	EMP. BEN. - S. BOGEN	" "	11	2	3,320				10
11	27	EMP. BEN. - S. LEVY	" "	45	11	18,630		3	1,271	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	4,292				12
13	27	EMP. BEN. - NON-OWNER	" "	45	9	23,348		3	1,785	13
14	27	EMP. BEN. - S. AARON	" "	40	11	12,346		3	842	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 14,972	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						352	9
10	39	ANCILLARY EXPENSE	" "						199	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 551	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK FINANCIAL		X	TERM NOTE			$	$ 205,000			$ 12,299	1
2												2
3												3
4			X	INSURANCE FINANCING							1,761	4
5	BANK FINANCIAL		X	PURCHASE VAN				23,462			2,340	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				240,816		PRIME+	16,242	6
7	INTERCOMPANY	X		WORKING CAPITAL				265,600			12,833	7
8	RELATED PARTY	X									2,288	8
9	TOTAL Facility Related						$	$ 734,878			$ 47,763	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 734,878			$ 47,763	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	42,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,730	2
3. Under or (over) accrual (line 2 minus line 1).	$	730	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	44,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	44,730	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999	39,958	9
2000	41,065	10
2001	41,449	11
2002	42,730	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GILMAN NURSING PAVILION COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0044263

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	NURSING HOME	$ 42,730.00	$ 42,730.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,730.00	$ 42,730.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,600
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1,720
4. Dates Incurred: 1/99

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8					29,869	766	35	853	87	8,818	8
	Improvement Type**										
9	SECURITY CAMERAS			1999	3,500	90	39	90		416	9
10	AIR SYSTEM IN KITCHEN			1999	1,200	31	39	31		128	10
11	FIRE DOOR			1999	8,757	225	39	225		969	11
12	FLOOR TILE, VINYL, WALLPAPER			1999	47,922	1,229	39	1,229		5,109	12
13	BLINDS/CURTAINS			2000	473	68	20	24	(44)	176	13
14	PICKET FENCE IMPROVEMENTS			2000	957	64	20	48	(16)	184	14
15	WALLPAPER/HANDRAILS/BUMPERGUARDS			2000	62,558	2,276	27.5	2,276		8,599	15
16	NURSE STATION			2000	29,619	1,077	27.5	1,077		4,066	16
17	ROOM /COMMON AREA SIGNS			2000	2,761	100	27.5	100		367	17
18	AIR CONSITIONER/COMPRESSOR			2000	5,096	185	27.5	185		689	18
19	WINDOW/DOOR			2000	3,011	109	27.5	109		427	19
20	WATER HEATER/ VALVE			2000	2,492	91	27.5	91		340	20
21	SOFFIT/FACIA REPAIR			2000	9,746	354	27.5	354		1,088	21
22	GAS LINE INSTALLATION			2000	3,119	113	27.5	113		438	22
23	WATER HEATERS/WATER SOFTENERS			2001	13,740	500	27.5	500		1,228	23
24	WINDOWS			2001	1,493	54	27.5	54		121	24
25	WALL CABINET			2001	743	27	27.5	27		55	25
26	DOORS			2002	1,823	66	27.5	66		102	26
27	GENERATOR / FAN COIL			2002	1,469	53	27.5	53		82	27
28	SMOKE DETECTOR / FIRE CONTROL PANEL			2002	12,098	440	27.5	440		654	28
29	BLINDS			2002	1,246	279	20	62	(217)	62	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 243,692	$ 8,197		$ 8,007	$ (190)	$ 34,118	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 149,402	$ 19,591	$ 14,940	$ (4,651)	10	$ 49,118	71
72	Current Year Purchases	9,133	4,703	457	(4,246)	10	457	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	18,325	1,010	1,440	430	10	12,489	74
75	TOTALS	$ 176,860	$ 25,304	$ 16,837	$ (8,467)		$ 62,064	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD BUS	2001	$ 51,478	$ 9,884	$ 10,296	$ 412		$ 37,065	76
77	RELATED PARTY			3,791	642	1,085	443		3,715	77
78										78
79										79
80	TOTALS			$ 55,269	$ 10,526	$ 11,381	$ 855		$ 40,780	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 475,821	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,027	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,225	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,802)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 136,962	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GILMAN ASSOCIATES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	1/1/99	$ 462,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 462,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: AFTER JULY 1, 2006-$4,702,500 *

10. Effective dates of current rental agreement:
Beginning 01/01/1999
Ending 12/31/2016

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	01/01/2004	$ 498,660
13.	01/01/2005	$ 505,896
14.	01/01/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,088 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	01 HONDA ACCORD LX	$ 339.00	$ 4,068	17
18	PAYROLL DEDUCTION			(2,817)	18
19					19
20					20
21	TOTAL		$ 339.00	$ 1,251	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GILMAN NURSING PAVILION

STATE OF ILLINOIS
0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 60,398	$		$ 60,398	1
2	Licensed Speech and Language Development Therapist		hrs			2,761			2,761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			62,580			62,580	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				61,315		61,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB,RADIOLOGY Other (specify):					3,427	4,051		7,478	13
14	TOTAL			$		$ 129,166	$ 65,366		$ 194,532	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	513,277		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,568		6
7	Other Prepaid Expenses	3,105		7
8	Accounts Receivable (owners or related parties)	52,720		8
9	Other(specify): RE TAX & INS ESCROW	54,599		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 651,269	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	213,823		15
16	Equipment, at Historical Cost	210,013		16
17	Accumulated Depreciation (book methods)	(180,826)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe RENT SEC DEP	237,600		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 480,610	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,131,879	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 241,454	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	734,878		29
30	Accrued Salaries Payable	188,366		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,991		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,000		32
33	Accrued Interest Payable	4,350		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,221,039	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,221,039	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (89,160)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,131,879	$	48

*(See instructions.)

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 122,423	1
2	Restatements (describe):		2
3		(10,261)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 112,162	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(201,322)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (201,322)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (89,160)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,267,720	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,267,720	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	51,657	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 51,657	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	207	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 207	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	537	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 537	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,320,121	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	633,659	31
32	Health Care	1,268,060	32
33	General Administration	772,835	33
	B. Capital Expense		
34	Ownership	598,154	34
	C. Ancillary Expense		
35	Special Cost Centers	194,532	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,521,443	40
41	**Income before Income Taxes (line 30 minus line 40)****	(201,322)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (201,322)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,478	1,751	$ 46,238	$ 26.41	1
2	Assistant Director of Nursing	1,916	2,029	39,180	19.31	2
3	Registered Nurses	6,605	7,319	144,534	19.75	3
4	Licensed Practical Nurses	20,304	22,875	370,918	16.21	4
5	Nurse Aides & Orderlies	44,132	47,654	457,746	9.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,118	2,714	34,171	12.59	9
10	Activity Assistants	5,098	5,426	55,409	10.21	10
11	Social Service Workers	2,075	2,265	36,906	16.29	11
12	Dietician	1,851	2,222	29,145	13.12	12
13	Food Service Supervisor					13
14	Head Cook	6,381	7,095	53,546	7.55	14
15	Cook Helpers/Assistants	10,503	11,839	90,015	7.60	15
16	Dishwashers					16
17	Maintenance Workers	2,597	2,569	28,904	11.25	17
18	Housekeepers	9,634	10,935	95,605	8.74	18
19	Laundry	4,389	4,814	35,148	7.30	19
20	Administrator	1,824	2,169	68,766	31.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,588	2,835	37,101	13.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,303	1,494	23,988	16.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,796	138,005	$ 1,647,320 *	$ 11.94	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 5,280	1-3	35
36	Medical Director	24	1,200	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	107	4,260	10-3	39
40	Physical Therapy Consultant	35	1,774	10a-3	40
41	Occupational Therapy Consultant	46	1,836	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	1	26	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	37	1,924	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	405	$ 16,300		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDITH PREE	ADMIN		$ 68,766
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,766

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING	$ 15,081
FROST RUTTENBERG	ACCOUNTING	3,165
OSTROW REISEN BERK	ACCOUNTING	1,523
SACHNOFF WEAVER	LEGAL	1,227
GIFFIN WINNING COHEN	LEGAL	237
PERSONNEL PLANNERS	UC CONSULTANT	900
ECONOCARE	PURCHASING CONSLT	1,835
DART CHART	MEDICARE CONSLT	2,436
HEALTH DATA SYSTEMS	DATA PROCESSING	3,656
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,060

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 51,227
Unemployment Compensation Insurance		9,449
FICA Taxes		122,760
Employee Health Insurance		53,552
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		8,518
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 350
Advertising: Employee Recruitment	25
Health Care Worker Background Check	930
(Indicate # of checks performed 78)	
MARKETING/ADV/PROMO	27,308
TRUST/FRANCHISE/CONTRIB/ETC	2,344
LICENSES & PERMITS	808
DUES & SUBSCRIPTIONS	5,089
MGMT CO ALLOCATION	648
TRUST/FRANCHISE/CONTRIB/ETC	(2,344)
Less: Public Relations Expense	(0)
Non-allowable advertising	(27,308)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,850

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
REALTED PARTY	393
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 393

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $3937**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **1674**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,233** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees